AN EXAMINATION OF THE EROSION IN LEGAL PROHIBITIONS AGAINST EUTHANASIA: A TRIBUTE TO LEO ALEXANDER, M.D.

NOTRE DAME UNIVERSITY LAW SCHOOL

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GOOD AFTERNOON.

I FIND IT PARTICULARLY APPROPRIATE TO BE ADDRESSING THIS AUDIENCE ON THE EVE OF JANUARY 22ND. TOMORROW IS THE THIRTEENTH ANNIVERSARY OF THE DECISION OF THE UNITED STATES SUPREME COURT IN ROE v. WADE, WHICH LEGALIZED ABORTION ON DEMAND THROUGHOUT THE FIRST SIX MONTHS OF PREGNANCY, AND MADE ABORTION FREELY AVAILABLE THROUGH THE FINAL THREE MONTHS OF PREGNANCY AS WELL.

MY PURPOSE TODAY IS TO ADDRESS A RELATED ISSUE OF LIFE AND DEATH WHICH, IN THE COMING GENERATION, MAY SURPASS EVEN THE ISSUE OF ABORTION AS A MATTER OF MORAL, LEGAL, AND MEDICAL CONTROVERSY. THAT ISSUE IS EUTHANASIA.

THIRTEEN YEARS AGO, WHEN ROE v. WADE WAS DECIDED, THE ISSUE OF EUTHANASIA WAS PERHAPS OF MORE ACADEMIC THAN PRACTICAL INTEREST. IN THAT YEAR, JOSEPH FLETCHER, A PROMINENT EPISCOPALIAN THEOLOGIAN WHO FAVORS ACTIVE EUTHANASIA, MADE THIS PREDICTION:

"THE DAY WILL COME WHEN PEOPLE WILL BE ABLE TO CARRY A CARD, NOTARIZED AND LEGALLY EXECUTED, WHICH EXPLAINS THAT THEY DO NOT WANT TO BE KEPT ALIVE BEYOND THE HUMANUM POINT, AND AUTHORIZING THE ENDING OF THEIR BIOLOGICAL PROCESSES BY ANY OF THE METHODS OF EUTHANASIA WHICH SEEMS APPROPRIATE."

BY HUMANUM POINT, FLETCHER MEANT THAT POINT AT WHICH THE ADULT CAPACITIES FOR REASON AND COMMUNICATION HAVE BEEN LOST.

THOSE OF YOU WHO VIEWED THE JANAURY 5TH EDITION OF SIXTY MINUTES DISCOVERED THAT IN A WESTERN DEMOCRATIC SOCIETY, THE NETHERLANDS, FLETCHER'S VISION OF EUTHANASIA ON REQUEST HAS COME TO PASS. THE 60 MINUTES REPORT REVEALED THAT OF ALL DEATHS THAT OCCUR IN HOLLAND EACH YEAR, ACCOUNTING FOR ALL CAUSES, FULLY ONE-SIXTH ARE ATTRIBUTABLE TO EUTHANASIA. THE DUTCH VERSION OF THE LIVING WILL GOES BEYOND THAT WHICH HAS BEEN ENACTED IN 35 OF OUR STATES, FOR PATIENTS CAN REQUEST BY SUCH A DOCUMENT THAT THEY BE ADMINISTERED A LETHAL INJECTION.

MOREOVER, THE PRACTICE OF EUTHANASIA HAS BECOME AN EVERYDAY PART OF DUTCH MEDICINE, FULLY SANCTIONED BY THAT COUNTRY'S EQUIVALENT OF THE A.M.A. ★

THE SITUATION IN THIS COUNTRY IS NOT AS GRAVE. BUT FOR THOSE WHO ARE CONCERNED ABOUT EUTHANASIA, IT IS NOT A TIME FOR COMPLANCENCY:

THE HEMLOCK SOCIETY, A LEADING AMERICAN ADVOCATE OF LEGAL EUTHANASIA, IS PREPARING LEGISLATION THAT IT CLAIMS WILL BE INTRODUCED THIS YEAR IN THREE STATES: ARIZONA, CALIFORNIA AND FLORIDA. THE LEGISLATION WILL PERMIT EUTHANASIA ACCORDING TO THE "DUTCH MODEL": AT THE REQUEST OF THE TERMINALLY ILL PATIENT, AND ADMINISTERED BY A PHYSICIAN.

IN THE NATION'S COURTS, THERE ARE AN INCREASING NUMBER OF CASES, AT LEAST FIVE ACTIVE IN THE PAST YEAR, WHERE LITIGANTS ARE SEEKING TO HAVE FEEDING TUBES WITHDRAWN FROM INCOMPETENT MEMBERS OF THEIR FAMILIES.

SUCH DEVELOPMENTS TEACH US THAT THE PUBLIC DEBATE OVER DEATH AND DYING--AND THE LEGAL CONTROVERSIES WHICH FUEL THAT DEBATE--HAVE COME A LONG WAY IN THE DECADE SINCE THE CASE OF KAREN ANN QUINLAN WAS DECIDED.

NO LONGER ARE WE JUST CONCERNED WITH PERMITTING THE TERMINALLY ILL TO "DIE WELL ENOUGH". NOW, THE QUESTION HAS TURNED TO WHAT DANIEL CALLAHAN, OF THE HASTINGS CENTER, TERMS THE "BIOLOGICALLY TENACIOUS" --- PATIENTS WHO SIMPLY DO NOT DIE WITHIN AN ACCEPTABLE TIME FRAME, AS DETERMINED BY THEIR FAMILIES OR BY SOCIETY. THUS, INCREASING SUPPORT IS SEEN FOR THE LEGALIZATION OF DECISIONS WHICH ARE MADE WITH THE DIRECT INTENT OF CAUSING THE DEATH OF THE PATIENT. THIS SUPPORT IS SEEN IN THE LITERATURE OF MEDICAL ETHICS, AND EVEN MORE STRONGLY IN POLLS OF PUBLIC OPINION. OVER 75 PERCENT OF RESPONDENTS SUPPORTED ACTIVE EUTHANASIA IN AN ASSOCIATED PRESS POLL TAKEN IN EARLY 1985. ★

EVEN MORE IMPORTANT THAN THESE FACTORS ARE THE DEMOGRAPHIC AND ECONOMIC CHANGES THAT CONFRONT THE NEXT TWO GENERATIONS OF AMERICAN SOCIETY.

THESE CHANGES HAVE ALREADY IMPELLED SIGNIFICANT REFORM IN MEDICARE. IN THE FUTURE, HOSPITALS WILL BE REIMBURSED NOT ACCORDING TO THEIR COSTS, BUT ACCORDING TO A FEE SCHEDULE SET BY GOVERNMENT AND BASED ON DIAGNOSTIC-RELATED GROUPS - DRG's. IN RESPONSE, HOSPITALS ARE BECOMING INCREASINGLY COST-CONSCIOUS AND SOPHISTICATED IN THEIR BUSINESS MANAGEMENT. DR. MARK SIEGLER, A CLINICIAN AND ETHICIST AT THE UNIVERSITY OF CHICAGO MEDICAL CENTER, SAYS THAT THESE FACTORS HAVE CREATED A NEW FACTOR IN MEDICAL DECISION-MAKING, WHICH HE CALLS "BUREAUCRATIC PARSIMONY." HE QUESTIONS WHETHER THE MEDICAL TRADITION OF SERVING THE BEST INTERESTS OF EVERY PATIENT CAN SURVIVE THIS ERA OF BUREAUCRATIC PARSIMONY.

YET, WHEN ONE CONSIDERS THE SHEER NUMBERS OF ELDERLY PEOPLE THAT WILL REQUIRE CARE IN FUTURE GENERATIONS, THE DILEMMA APPEARS STAGGERING. DURING THE NEXT 45 YEARS, THE NUMBER OF PERSONS ABOVE THE AGE OF 65 WILL INCREASE 100 PERCENT, FROM 29 MILLION TO AT LEAST 64 MILLION. DURING THE SAME TIME, THE NUMBER OF PERSONS IN THE RANGE OF AGES 20 TO 64--THE LIKELY WAGE-EARNERS--WILL INCREASE ONLY 30 PERCENT, FROM 145 MILLION TO 185 MILLION.

THUS, WHERE THERE ARE NOW FIVE YOUNG AND MIDDLE-AGED ADULTS TO CARE FOR EVERY ELDERLY PERSON, THERE WILL ONLY BE THREE BY THE TIME THE STUDENTS AMONG YOU REACH YOUR RETIREMENT. THESE FIGURES, OF COURSE, ARE NOT WRITTEN IN STONE, AND MAY BE AFFECTED BY CHANGES IN THE BIRTH-RATE AND SO FORTH. BUT THE FIGURES I HAVE GIVEN YOU ARE BASED ON AN OPTIMISTIC FORECAST OF A BIRTHRATE OF 2.3 CHILDREN PER AMERICAN WOMAN. THAT FIGURE NOW STANDS AT 1.8 CHILDREN, AND IF IT DOES NOT CHANGE, THE PROPORTION OF ELDERLY TO WAGE-EARNERS WILL BE EVEN HIGHER.

ONE PURPOSE OF MY ADDRESS TODAY IS TO ALERT YOU TO THE FACT THAT THE ISSUE OF EUTHANASIA IS ONE THAT WILL CONFRONT YOU THROUGHOUT YOUR PROFESSIONAL LIVES. I HOPE MY REVIEW OF THE CURRENT SITUATION AND FUTURE DEMOGRAPHICS HAVE SERVED THAT PURPOSE. ANOTHER GOAL, TO WHICH I WILL DEVOTE MOST OF THIS ADDRESS, IS TO REVIEW THE CHANGES IN THE LAW, BOTH LEGISLATIVE AND JUDICIAL, THAT HAVE TAKEN PLACE IN THE PAST DECADE AND WHICH HAVE AN IMPACT ON THE EUTHANASIA ISSUE.

AMONG THESE DEVELOPMENTS ARE STATUTES DEFINING BRAIN DEATH, AND PERMITTING THE EXECUTION OF LIVING WILLS. EVEN MORE IMPORTANT MAY BE COURT DECISIONS, STARTING WITH THE CASE OF KAREN QUINLAN. IN ORDER TO ADDRESS THESE DEVELOPMENTS IN THE TIME I HAVE AVAILABLE, I HAVE TO BE SELECTIVE. ACCORDINGLY, I WILL FOCUS ATTENTION ON TWO PIECES OF LEGISLATION--THE UNIFORM DETERMINATION OF DEATH ACT, AND THE UNIFORM RIGHTS OF THE TERMINALLY ILL ACT--AND ON TWO COURT CASES--THE CASE OF KAREN QUINLAN AND THE CASE OF CLAIRE CONROY, BOTH OF WHICH WERE DECIDED BY THE SUPREME COURT OF NEW JERSEY.

THE FOCUS OF THIS ADDRESS, THEREFORE, WILL BE IN ANSWERING WHAT MIGHT BE CALLED THE "WHAT" QUESTIONS REGARDING EUTHANASIA. STILL TO BE ANSWERED IS THE QUESTION OF "WHY"--WHY IT IS IMPORTANT FOR THE LEGAL PROFESSION TO BE CONCERNED ABOUT LEGAL DEVELOPMENTS THAT MAY LEAD TO THE EROSION OF THE EXISTING PROHIBITIONS AGAINST EUTHANASIA. IN LIEU OF ANSWERING THAT QUESTION MYSELF, I HAVE DEDICATED THIS ADDRESS TO THE MEMORY OF A MAN WHO ANSWERED IT AS WELL AS ANY PERSON IN THIS CENTURY. HE WAS MY FRIEND AND HE DIED LAST YEAR

DR. LEO ALEXANDER WAS A NATIVE OF AUSTRIA WHO EMIGRATED TO THE UNITED STATES AND BECAME A PROFESSOR OF PSYCHIATRIC MEDICINE IN BOSTON. HE SERVED AS AN EXPERT AT THE NUREMBERG TRIALS OF THOSE PHYSICIANS WHO HAD ENGINEERED THE GERMAN EUTHANASIA PROGRAM, AND, EVENTUALLY, THE INFAMOUS MEDICAL EXPERIMENTS AND GENOCIDE CARRIED OUT BY THE NAZI REGIME. HE CARRIED WITH HIM ONE SPECIAL ADVANTAGE IN THIS WORK--AS A NATIVE SPEAKER OF GERMAN, HE WAS ABLE TO GAIN THE CONFIDENCE OF THE DEFENDANTS DURING PRIVATE INTERVIEWS, THUS OPENING UP NEW STORES OF DATA REGARDING THE ORIGINS OF WHAT HISTORY NOW CALLS THE HOLOCAUST. HE REPORTED HIS FINDINGS FOR THE MEDICAL PROFESSION IN AN ESSAY PUBLISHED BY THE NEW ENGLAND JOURNAL OF MEDICINE IN 1948. THE FOLLWING EXCERPTS FROM THAT ESSAY REFLECT WHAT THE EXPERIENCE OF THIS CENTURY SHOULD TEACH US ABOUT EUTHANASIA.

"WHATEVER PROPORTIONS THESE CRIMES FINALLY ASSUMED, IT BECAME EVIDENT TO ALL WHO INVESTIGATED THEM THAT THEY HAD STARTED FROM SMALL BEGINNINGS. THE BEGINNINGS AT FIRST WERE MERELY A SUBTLE SHIFT IN EMPHASIS IN THE BASIC ATTITUDE OF PHYSICIANS.

"IT STARTED WITH THE ACCEPTANCE OF THE ATTITUDE, BASIC IN THE EUTHANASIA MOVEMENT, THAT THERE IS SUCH A THING AS A LIFE NOT WORTHY TO BE LIVED.

"THIS ATTITUDE IN ITS EARLY STAGES CONCERNED ITSELF MERELY WITH THE SEVERELY AND CHRONICALLY SICK. GRADUALLY THE SPHERE OF THOSE TO BE INCLUDED IN THIS CATEGORY WAS ENLARGED TO ENCOMPASS THE SOCIALLY UNPRODUCTIVE, THE IDEOLOGICALLY UNWANTED, AND FINALLY ALL NON-GERMANS. BUT IT IS IMPORTANT TO REALIZE THAT THE INFINITELY SMALL WEDGED-IN LEVER FROM WHICH THIS ENTIRE TREND OF MIND RECEIVED ITS IMPETUS WAS THE ATTITUDE TOWARD THE NONREHABILITABLE SICK."

LET'S TAKE A LOOK AT THE LAST SIX WORDS OF THIS EXCERPT--THE ATTITUDE TOWARD THE NONREHABILITABLE SICK. WHATEVER SIDE ONE TAKES IN THE CURRENT DEBATE OVER EUTHANASIA AND THE PROVISION OF MEDICAL TREATMENT, OR EVEN IF ONE CANNOT TAKE A SIDE, ONE CANNOT DENY THAT OUR OWN ATTITUDE TOWARDS THOSE WHO ARE SICK, INFIRM AND WILL NOT RECOVER IS UNDER SERIOUS EXAMINATION. THE LESSON OF LEO ALEXANDER'S ANALYSIS IS THAT WE CANNOT TAMPER WITH OUR

ATTITUDE TOWARD SUCH PATIENTS WITHOUT BEING COGNIZANT OF THE IMPACT OUR TAMPERING MAY HAVE ON THE PRACTICE OF EUTHANASIA. DR. ALEXANDER WAS AWARE OF THE VAST DIFFERENCES BETWEEN NAZI GERMANY AND THE UNITED STATES, BUT HE WAS ALSO AWARE THAT, EVEN FORTY YEARS AGO, A UTILITARIAN ETHIC WAS VERY PERVASIVE IN AMERICAN MEDICINE. I QUOTE AGAIN FROM HIS 1948 ESSAY:

"THE KILLING CENTER IS THE REDUCTIO AD ABSURDUM OF ALL HEALTH PLANNING BASED ONLY ON RATIONAL PRINCIPLES AND ECONOMY AND NOT ON HUMAN COMPASSION AND DIVINE LAW.

"TO BE SURE, AMERICAN PHYSICIANS ARE STILL FAR FROM THE POINT OF THINKING OF KILLING CENTERS, BUT THEY HAVE ARRIVED AT A DANGER POINT IN THINKING, AT WHICH LIKELIHOOD OF FULL REHABILITATION IS CONSIDERED A FACTOR THAT SHOULD DETERMINE THE AMOUNT OF TIME, EFFORT AND COST TO BE DEVOTED TO A PARTICULAR TYPE OF PATIENT ON THE PART OF THE SOCIAL BODY UPON WHICH THIS DECISION RESTS.

"AT THIS POINT, AMERICANS SHOULD REMEMBER THAT THE ENORMITY OF A EUTHANASIA MOVEMENT IS PRESENT IN THEIR OWN MIDST." ★

ONE OF THE DIFFICULTIES IN DISCUSSING THE WORK OF DR. ALEXANDER TODAY IS THE WIDESPREAD CONFUSION OVER WHAT WE MEAN WHEN WE SPEAK OF EUTHANASIA. LIKE MANY OTHER AREAS OF LEGAL REFORM, EUTHANASIA HAS UNDERGONE A CHANGE IN OUR VOCABULARY THAT IS IN PART INSPIRED BY THE POLITICAL AIMS OF SOME OF THE PARTICIPANTS IN THAT DEBATE. FOR EXAMPLE, THE EUTHANASIA SOCIETY OF AMERICA, FOUNDED IN THE 1930s, CHANGED ITS NAME IN THE MID-1970s TO THE SOCIETY FOR THE RIGHT TO DIE. THE SOCIETY ACKNOWLEDGED THAT THE INTENT TO AVOID THE CONTROVERSY ENGENDERED BY THE TERM "EUTHANASIA" PLAYED A PART IN THIS DECISION. "RIGHT TO DIE" HAS BECOME A CATCH-WORD IN THIS DEBATE, BUT ONE THAT IS NOT WELL-UNDERSTOOD. DOES IT SIMPLY MEAN THE RIGHT OF A COMPETENT PERSON TO REFUSE LIFE-SUSTAINING TREATMENTS WHEN DEATH IS IMMINENT? OR DOES IT EXTEND TO INCOMPETENT PATIENTS AS WELL? AND DOES IT ENCOMPASS MEANS OF DIRECTLY BRINGING DEATH, WHETHER BY REMOVAL OF MEDICAL TREATMENT OR ACTIVE, LETHAL INJECTIONS? THUS, TO AFFIRM THAT PERSONS HAVE A "RIGHT TO DIE" STILL LEAVES MANY UNANSWERED QUESTIONS.

A MORE PRECISE USE OF TERMS WOULD ASSIST IN CLEARING UP MUCH OF THE CONFUSION IN THIS DEBATE. I USE THE TERM EUTHANASIA TO MEAN THE WILFUL AND DELIBERATE KILLING, WHETHER BY ACT OR OMISSION, OF ONESSELF OR ANOTHER OUT OF MOTIVES OF COMPASSION, THE DESIRE TO SAVE ANOTHER FROM SUFFERING, OR TO PROMOTE THE "DIGNITY" OF THE SUFFERING PERSON.

THIS AUDIENCE WILL IMMEDIATELY RECOGNIZE THAT THIS DEFINITION PLACES FOCUS UPON THE STATE OF MIND AND INTENT OF THE DECISION-MAKER, NOT UPON THE MEANS USED. THIS IS APPROPRIATE BECAUSE APOLOGISTS FOR EUTHANASIA HAVE CONSISTENTLY USED THE COMPASSIONATE MOTIVE OF THOSE WHO HAVE COMMITTED EUTHANASIA AS A GROUNDS FOR ITS LEGALIZATION. IN ADDITION, WE AVOID BY THIS DEFINITION A SITUATION WHERE CERTAIN ACTIONS--WITHDRAWING A RESPIRATOR, FOR EXAMPLE--ARE AUTOMATICALLY EXONERATED, WHILE OTHER ACTIONS--REMOVING A FEEDING TUBE, FOR EXAMPLE--ARE AUTOMATICALLY SUSPECT AS EUTHANASIA. THE VATICAN DECLARATION ON EUTHANASIA, ISSUED IN 1980, STATES AS FOLLOWS: "EUTHANASIA'S TERMS OF REFERENCE ARE TO BE FOUND IN THE INTENTION OF THE WILL AND IN THE METHODS USED."

THE FOCUS ON THE ACTOR'S INTENT ALSO AVOIDS THE DIFFICULTIES THAT ARISE WHEN A DISTINCTION IS MADE BETWEEN PASSIVE AND ACTIVE EUTHANASIA. PASSIVE EUTHANASIA IS SIMPLY AN OMISSION OF TREATMENT WITH THE INTENT OF BRINGING ABOUT DEATH. DELIBERATE STARVATION OF A PATIENT MAY BE AN EXAMPLE OF THIS. ACTIVE EUTHANASIA BRINGS ABOUT DEATH BY MORE DIRECT MEANS, SUCH AS INJECTION OF A LETHAL DRUG.

IF WE WERE ONLY TO MAINTAIN A PROHIBITION AGAINST ACTIVE MEANS OF EUTHANASIA, AND ACCEPTED PASSIVE EUTHANASIA, THE TOLL OF HUMAN LIFE WOULD STILL BE SUBSTANTIAL. THERE IS A SUBSTANTIAL POPULATION OF PERSONS, SOME ELDERLY, SOME DISABLED, WHO ARE DEPENDENT UPON SOME FORM OF LIFE-SUPPORT. THE PRACTICE OF PASSIVE EUTHANASIA COULD JEOPARDIZE THE LIVES OF ALL OF THESE PATIENTS. AND THE RESULTING ACCEPTANCE OF DEATH FOR SUCH PATIENTS WOULD CREATE A CLIMATE OF SUPPORT FOR MORE ACTIVE MEANS OF EUTHANASIA.

FINALLY, OUR DEFINITION WILL PROVIDE A RELIABLE BASIS FOR DISTINGUISHING BETWEEN ACTS OF PASSIVE EUTHANASIA ON THE ONE HAND, AND LEGITIMATE DECISIONS TO WITHDRAW MEDICAL TREATMENT THAT IS FUTILE AND BURDENSOME TO A PATIENT. THE EFFECT OF SUCH A DECISION TO WITHDRAW TREATMENT MAY BE THE DEATH OF THE PATIENT --- FOR THIS REASON, THE DISTINCTION BETWEEN SUCH DECISIONS AND EUTHANASIA IS ONE OF THE MOST DIFFICULT DILEMMAS FACING MEDICINE. THE EXISTENCE OF A CLEAR DEFINITION OF EUTHANASIA WILL NOT RESOLVE THAT DILEMMA ENTIRELY, BUT IT WILL HELP TO ENSURE THAT THE BENEFIT OF THE DOUBT IS GIVEN TO CONTINUED LIFE IN CLOSE ~~CASES~~ DECISIONS.

IN THE RECENT CONROY DECISION OF THE NEW JERSEY SUPREME COURT, IT WAS HELD THAT IN EVERY CASE WHERE LIFE-SUSTAINING TREATMENT IS SOUGHT TO BE WITHHELD FROM A TERMINALLY ILL, INCOMPETENT NURSING HOME PATIENT, THE NEW JERSEY OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY MUST CONDUCT AN INVESTIGATION. FURTHER, THE OMBUDSMAN IS TO TREAT EVERY SUCH CASE AS A POTENTIAL INSTANCE OF PATIENT ABUSE.

ACCORDINGLY, IT DOES SEEM INAPPROPRIATE TO DEFINE EUTHANASIA SO THAT DECISION-MAKERS RECOGNIZE THAT ANY CASE OF WITHDRAWAL OF LIFE-SUPPORT IS A POTENTIAL CASE OF EUTHANASIA.

SO MUCH FOR THE DEFINITION OF EUTHANASIA. I NOW TURN TO THE FIRST OF OUR DESIGNATED TOPICS FOR LEGAL DISCUSSION, THE STATUTORY DEFINITION OF DEATH BY NEUROLOGICAL CRITERIA; IN MORE PROSAIC TERMS, "BRAIN DEATH".

PROPERLY UNDERSTOOD, THE DIAGNOSIS OF DEATH BY NEUROLOGICAL CRITERIA IS NOT A RADICAL DEPARTURE FROM THE TRADITIONAL CARDIO-RESPIRATORY DIAGNOSIS OF DEATH. NOR IS IT INTENDED TO HASTEN THE DIAGNOSIS OF DEATH IN TERMINALLY ILL PATIENTS. FORTUNATELY, THE CURRENT LEGAL STANDARDS FOR BRAIN DEATH REFLECT THIS UNDERSTANDING.

UNDER THE COMMON LAW, DEATH WAS DIAGNOSED WHEN THERE WAS A PERMANENT AND IRREVERSIBLE LOSS OF RESPIRATORY AND CIRCULATORY FUNCTION. IT WAS NOT NECESSARY TO SPECIFY THAT THIS MEANT THE LOSS OF <u>SPONTANEOUS</u> FUNCTION, FOR NO TECHNOLOGY EXISTED WHICH WOULD PERMIT THESE VITAL FUNCTIONS TO BE MAINTAINED ARTIFICIALLY.

EVENTUALLY, such TECHNOLOGY WAS DEVELOPED. THE QUESTION THEN AROSE AS TO WHETHER A DIAGNOSIS OF DEATH COULD BE MADE WHEN THERE HAD BEEN A LOSS OF ALL OF THE FUNCTIONS OF THE ENTIRE BRAIN, INCLUDING THE BRAIN STEM, WHICH DIRECTS RESPIRATION AND CIRCULATION, BUT WHEN THESE VITAL FUNCTIONS WERE BEING MAINTAINED ARTIFICIALLY.

THE ANSWER OF THE MEDICAL AND LEGAL PROFESSIONS WAS IN THE AFFIRMATIVE. A JOINT COMMITTEE OF THE A.B.A. AND THE A.M.A. DRAFTED THE UNIFORM DETERMINATION OF DEATH ACT, WHICH PERMITS THE DIAGNOSIS OF DEATH WHEN THERE HAS BEEN AN IRREVERSIBLE CESSATION OF ALL FUNCTIONS OF THE ENTIRE BRAIN, INCLUDING THE BRAIN STEM.

THE NEXUS OF BRAIN DEATH WITH EUTHANASIA IS SEEN IN THE PROPOSALS TO DEFINE DEATH BY LESS FIXED CRITERIA. IN ESSENCE, THESE CRITERIA WOULD PERMIT A DETERMINATION OF DEATH WHEN THERE WAS LOSS OF ALL CORTICAL, OR UPPER-BRAIN FUNCTION. THIS WOULD PARALLEL THE REASONING OF JOSEPH FLETCHER, THAT HUMAN LIFE IS LOST WHEN THE ABILITY TO REASON IS LOST. ACCEPTANCE OF THIS DEFINITION WOULD CONVERT BRAIN DEATH LEGISLATION INTO A RE-CLASSIFICATION OF LIVING PATIENTS AS DEAD PATIENTS.

ALTHOUGH THE UNIFORM ACT SERVES AS A PROTECTION AGAINST EUTHANASIA, MEDICAL AND LEGAL DILEMMAS WILL PERSIST ON ALTHO. A PATIENT IS DEAD WHEN THE PHYSICIAN SAYS SO, THIS ISSUE. YOU OUGHT TO BE AWARE OF DILEMMAS OF TWO TYPES.

FIRST IS THE SELECTION OF CRITERIA USED TO DIAGNOSE DEATH. THE UNIFORM ACT DOES NOT, OF COURSE, SPECIFY THE PRECISE MEDICAL STANDARDS THAT MUST BE EMPLOYED. THE ISSUE OF WHETHER DEATH HAS BEEN PROPERLY DIAGNOSED ACCORDING TO NEUROLOGICAL CRITERIA HAS ARISEN IN CRIMINAL CASES, AND COULD APPEAR IN CIVIL ACTIONS AS WELL.

SECOND IS THE ISSUE OF "TREATMENT " OF A BRAIN DEAD INDIVIDUAL. IF A PROPER DETERMINATION OF BRAIN DEATH HAS BEEN MADE, IT IS CLEARLY PERMISSIBLE TO CEASE ALL FURTHER MEDICAL TREATMENT. BUT IS IT OBLIGATORY? THAT ISSUE WAS RECENTLY RAISED IN A CIVIL SUIT IN MILWAUKEE, WHERE THE CITY HAS REFUSED TO PAY FOR TREATMENT GIVEN TO A SEVEN-YEAR BOY FOR A PERIOD OF 30 DAYS AFTER THE DIAGNOSIS OF BRAIN DEATH. CAN HOSPITALS FORCE FAMILIES TO ACCEPT A WITHHOLDING OF TREATMENT ONCE BRAIN DEATH HAS BEEN DIAGNOSED?

THE SECOND IMPORTANT LEGISLATIVE DEVELOPMENT IN THE FIELD OF EUTHANASIA IS THE LIVING WILL. 1985 WAS AN IMPORTANT YEAR FOR SUCH LEGISLATION. AT THE OUTSET OF LAST YEAR, LESS THAN HALF THE STATES HAD LIVING WILL LAWS. THAT NUMBER INCREASED TO 35 DURING THE YEAR. IN ADDITION, THE PRESTIGIOUS NATIONAL CONFERENCE OF COMMISSIOERS ON UNIFORM STATE LAWS ADOPTED A UNIFORM LIVING WILL LAW, CALLED THE "UNIFORM RIGHTS OF THE TERMINALLY ILL ACT". I WILL REFER TO THIS AS THE UNIFORM LIVING WILL ACT. AS A RESULT, THE LIVING WILL IS NOW A FIXTURE ON THE LEGISLATIVE SCENE, AND MUST BE CONSIDERED AN IMPORTANT COMPONENT IN DISCUSSING THE LEGAL ASPECTS OF EUTHANASIA.

THE BASIC FORMAT OF LIVING WILL LEGISLATION IS WELL-ESTABLISHED. SUCH LAWS PERMIT PERSONS TO WRITE A DECLARATION, WHILE COMPETENT, WHICH IS INTENDED TO GOVERN MEDICAL DECISIONS MADE FOR THEM WHEN THEY BECOME INCOMPETENT AND TERMINALLY ILL.

THE FORMS OF SUCH A DECLARATION VARY, BUT MOST OF THEM ARE SIMILAR TO THAT PROVIDED IN THE UNIFORM LIVING WILL LAW:

"IF I SHOULD HAVE AN INCURABLE OR IRREVERSIBLE CONDITION THAT WILL CAUSE MY DEATH WITHIN A RELATIVELY SHORT PERIOD OF TIME, AND IF I AM NO LONGER ABLE TO MAKE DECISIONS REGARDING MY MEDICAL TREATMENT, I DIRECT MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW TREATMENT THAT ONLY PROLONGS THE DYING PROCESS AND IS NOT NECESSARY TO MY COMFORT OR TO ALLEVIATE PAIN."

THE SIMPLICITY OF THIS LIVING WILL IS ONE OF ITS GREAT SELLING POINTS. BUT IT IS ALSO A POINT FOR GREAT CONCERN. IT IS TRUE THAT PATIENTS HAVE THE RIGHT NOT TO CONSENT TO MEDICAL TREATMENT--THIS IS WELL ESTABLISHED IN AMERICAN LAW AND HAS BEEN EXTENDED BY COURTS TO APPLY TO REMOTE STATEMENTS, SUCH AS THE LIVING WILL. THE RIGHT TO REFUSE TREATMENT, HOWEVER, IS PREMISED UPON THE SAME FACTORS AS THE DOCTRINE OF INFORMED CONSENT. IT ASSUMES THAT THE PATIENT, PROPERLY APPRISED OF THE RISKS AND BENEFITS OF TREATMENTS, IS THE BEST JUDGE OF HIS OWN INTERESTS IN RECEIVING OR NOT RECEIVING MEDICAL TREATMENT.

UNDER THE LIVING WILL, THESE PREMISES CLEARLY DO NOT EXIST. A LIVING WILL MAY BE SIGNED WHEN A PATIENT HAS NO KNOWLEDGE OF THE SPECIFIC MEDICAL CONDITIONS THAT MIGHT

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HIM, NOR OF THE MEDICAL TREATMENTS THAT MIGHT BE NECESSARY
HOW SIMPLE OR COMPLEX THEY MIGHT BE
TO SUSTAIN HIS LIFE; HE ALSO IS NOT AWARE OF WHAT HIS PERSONAL AND FAMILY CIRCUMSTANCES MIGHT BE.

FURTHERMORE, THE LIVING WILL, IN MOST CASES, GOES ONLY IN ONE DIRECTION, THE DIRECTION OF WITHHOLDING TREATMENT. THE DRAFTERS OF THE UNIFORM LIVING WILL LAW SPECIFICALLY REJECTED A PROPOSAL THAT PATIENTS BE PERMITTED TO REQUEST THAT THEIR LIVES BE SUSTAINED. IF THE INTENT OF SUCH LEGISLATION IS TO PRESERVE PATIENT RIGHTS, AS THE TITLE OF THE UNIFORM ACT APPLIES, WHY IS THE RIGHT TO CONSENT TO TREATMENT NOT INCLUDED?

FINALLY, THE LIVING WILL, UNDER MOST STATUTES, IS A LEGALLY BINDING DOCUMENT. IF ITS TERMS ARE STRICTLY FOLLOWED, IT REQUIRES THE WITHDRAWAL OF ALL LIFE-SUSTAINING TREATMENT WHENEVER A PATIENT IS IN AN IRREVERSIBLE TERMINAL CONDITION, AND IS INCOMPETENT TO MAKE MEDICAL TREATMENT DECISIONS. THE RISK OF NOT COMPLYING WITH A LIVING WILL IS VERY HIGH. A PHYSICIAN CAN BE SUBJECT TO CHARGES OF UNPROFESSIONAL CONDUCT OR EVEN MISDEMEANOR CRIMINAL CHARGES IF HE REFUSES TO COMPLY,
REFUSES
OR TO TRANSFER THE PATIENT TO SOMEONE WHO WILL.

A HEALTHY PERSON WHO EXECUTES A LIVING WILL MAY CONSIDER ANY NUMBER OF POTENTIAL VARIABLES BUT HE CANNOT, IN THE FINAL ANALYSIS, PREDICT THE FUTURE. APART FROM THE LIMITS OF HUMAN PERCEPTION AND IMAGINATION, THERE IS THE FACT THAT ADVANCES AND CHANGES IN MEDICAL SCIENCE MAY RENDER TODAY'S CONTEMPLATION OF THE MISERY OF TERMINAL ILLNESS OBSOLETE IN THE FUTURE. IF A PERSON, FOR EXAMPLE, IS IMPELLED TO SIGN A LIVING WILL BY THE PROSPECT OF PROLONGED, PAINFUL DEATH IN AN INTENSIVE CARE UNIT, SOME CHANGES AS SIMPLE AS ADVANCES IN PAIN CONTROL AND HOSPICE CARE MAY RENDER HIS ASSUMPTIONS INVALID. YET, HIS LIVING WILL WOULD REMAIN EFFECTIVE.

ONE MUST ALSO CONSIDER WHETHER THE "RIGHT TO DIE' PHILOSOPHY THAT IS SERVED BY THE LIVING WILL IS APPROPRIATE FOR LEGISLATION. MARK SIEGLER AND ALAN WEISBARD HAVE OBSERVED THAT THE INTERSECTION BETWEEN THE PHILOSOPHY OF COST-CONTAINMENT AND THE 'RIGHT TO DIE' COULD PROFOUNDLY AFFECT THE PRACTICE OF MEDICINE. THEY WRITE AS FOLLOWS.

"FOR AN INCREASING NUMBER OF PATIENTS, THE BENEFITS OF CONTINUED LIFE ARE PERCEIVED AS INSUFFICIENT TO JUSTIFY THE BURDEN AND COST OF CARE. DEATH IS THE DESIRED OUTCOME, AND THE ROLE OF THE PHYSICIAN IS TO PARTICIPATE IN BRINGING THIS ABOUT.

"COST CONTAINMENT STRATEGIES MAY IMPOSE SIGNIFICANT FINANCIAL PENALTIES ON THOSE WHO PROVIDE PROLONGED CARE FOR THE IMPAIRED ELDERLY. IN THE CURRENT ENVIRONMENT, IT MAY WELL PROVE CONVENIENT--AND ALL TOO EASY--TO MOVE FROM A RECOGNITION OF AN INDIVIDUAL'S 'RIGHT TO DIE' TO A CLIMATE ENFORCING A 'DUTY TO DIE'."

THESE FEARS ARE NOT IDLE. THE GOVERNOR OF COLORADO HAS SUGGESTED THAT THERE IS A DUTY FOR ELDERLY PERSONS TO DIE AND GET OUT OF THE WAY OF THE PRODUCTIVE YOUNGER GENERATION. SOME HEALTH POLICY PLANNERS HAVE PROPOSED THAT MEDICARE PATIENTS BE PROVIDED A LIVING WILL UPON ADMISSION TO THE HOSPITAL--TO SERVE THE INTERESTS OF COST CONTAINMENT. THE ISSUE OF HOW MUCH TREATMENT IS ENOUGH HAS CEASED TO BE A PRIVATE ISSUE BETWEEN PATIENT AND PHYSICIAN, AND NOW HAS IMPLICATIONS FOR THE ECONOMIC HEALTH OF THE HOSPITAL, AS WELL AS OF SOCIETY.

THE IMPACT OF LIVING WILL LEGISLATION UPON SUCH AN ENVIRONMENT IS LIKELY TO BE THAT OF FURTHER EROSION IN THE TRADITIONAL ETHIC OF PRIMUM NON NOCERE--DO NOT HARM. THE LIVING WILL ASSUMES THAT THE ONLY PROBLEM IS THE OVER-TREATED PATIENT. THE EMERGENCE OF DEATH AS A FAVORED OUTCOME IS ENHANCED BY THESE STATUTES.

IN PART, THIS HAS HAPPENED BECAUSE THE EUTHANASIA MOVEMENT HAS SEIZED UPON ~~THE GROWING FEAR~~ BETWEEN THE MEDICAL PROFESSION AND THE PUBLIC AT LARGE. MANY PATIENTS AND THEIR FAMILIES YEARN FOR AN EASY AND COMFORTABLE DEATH AS OPPOSED TO A PROLONGED DYING PROCESS. YET, I DO NOT BELIEVE THAT WE ARE SUFFICIENTLY AWARE AS A SOCIETY OF THE RISKS INVOLVED IN TRANSLATING THIS GOAL INTO PUBLIC POLICY. PROFESSOR YALE KAMISAR OF THE UNIVERSITY OF MICHIGAN LAW SCHOOL HAS POINTED OUT THAT THE PRICE OF MAINTAINING THE RIGHTS OF ALL TERMINALLY ILL PATIENTS TO LIFE AND ADEQUATE MEDICAL CARE MAY INCLUDE THE TEMPORARY PROLONGATION OF LIFE FOR CERTAIN INDIVIDUALS WHO WOULD RATHER DIE. THIS IS AN ACCEPTABLE COST, KAMISAR POINTED OUT, BECAUSE THE LIFE AND LIBERTIES OF ALL PERSONS ARE

BY A MEDICAL PROFESSION THAT IS DEDICATED TO THE PRESERVATION OF LIFE, NOT ITS DESTRUCTION. ★

PROFESSOR KAMISAR OFFERS AN ETHIC THAT IS QUITE FOREIGN TO THE CURRENT PHILOSOPHIES OF RIGHT TO DIE AND COST CONTAINMENT. IN CHOOSING BETWEEN THESE ETHICS, IT IS CLEAR WHICH ONE IS DEDICATED TO THE WELFARE OF THE INDIVIDUAL PATIENT. IT IS LIKEWISE CLEAR THAT LIVING WILL LEGISLATION IS A PRODUCT OF THE NEWER, RIGHT TO DIE ETHIC, AND POSES SERIOUS RISKS TO THE TRADITIONAL ETHICS OF MEDICAL PRACTICE, AS WELL AS TO PATIENTS' RIGHTS.

THESE DEFICIENCIES OF PRESENT LIVING WILL LEGISLATION, HOWEVER, SHOULD NOT BLIND US TO THE POSSIBILITY FOR POSITIVE LEGISLATIVE REFORM IN THIS AREA OF THE LAW. SOME OPPONENTS OF THE LIVING WILL ARE SUSPECT OF ALL LEGISLATIVE ACTIVITY IN THIS AREA. CERTAINLY, MUCH OF WHAT HAS HAPPENED ON THE LEGISLATIVE FRONT HAS NOT BEEN GOOD. BUT IF THE LEGISLATIVE ARENA IS IGNORED, IT IS MORE THAN LIKELY THAT THE COURTS WILL FILL THE VOID. THE STATE OF NEW JERSEY IS A PERFECT EXAMPLE OF THIS. POLITICAL FORCES HAVE PREVENTED THE ADVANCEMENT OF LIVING WILL FOR

MANY YEARS IN THAT STATE. IN THE ABSENCE OF LEGISLATIVE GUIDELINES, THE SUPREME COURT WROTE ITS OPINION IN THE CONROY CASE ON A CLEAR SLATE. EFFECTIVELY, WHAT THE COURT WROTE WAS A STATUTE TO GOVERN THE CARE OF ELDERLY, NURSING HOME PATIENTS. IF THE LEGISLATIVE ARENA IS ABDICATED, THIS PATTERN COULD CONTINUE IN OTHER STATES.

A RECENT CASE IN FLORIDA DEMONSTRATES THE POSITIVE EFFECT THAT LEGISLATION CAN HAVE UPON THE COURT'S PROPENSITY TO AUTHORIZE EUTHANASIA.

IN CORBETT v. D'ALESSANDRO, A HUSBAND SOUGHT THE REMOVAL OF A NASO-GASTRIC FEEDING TUBE FROM HIS WIFE, WHO WAS IN A PERSISTENT VEGETATIVE STATE. THE PATIENT WAS NOT IN A TERMINAL CONDITION, AND SHE HAD NOT AUTHORED A LIVING WILL.

FLORIDA, IN 1984, PASSED THE "LIFE PROLONGING PROCEDURE ACT". THIS IS A FORM OF LIVING WILL LAW. WHAT MAKES IT DIFFERENT FROM MANY OTHER LIVING WILL LAWS IS THAT SEVERAL OF ITS PROVISIONS WERE DRAFTED BY LAWYERS WORKING FOR THE CATHOLIC CHURCH. AS I UNDERSTAND IT, THE CHURCH DID NOT ENDORSE THIS LIVING WILL LEGISLATION, BUT MADE AN EFFORT

TO MITIGATE THE NEGATIVE IMPACT OF THE BILLS THROUGH THESE AMENDMENTS. ONE OF THESE AMENDMENTS WAS TO EXCLUDE NUTRITION AND HYDRATION FROM THE CATEGORY OF MEDICAL TREATMENT THAT CAN BE WITHDRAWN UNDER A LIVING WILL.

IN THE CORBETT CASE, EVEN THOUGH THE PATIENT WAS OUTSIDE THE SCOPE OF THOSE PATIENTS COVERED BY THE LIVING WILL, THE COURT FOUND THAT THIS AMENDMENT TO THE LIVING WILL LAW WAS A CLEAR STATEMENT OF PUBLIC POLICY THAT NUTRITION AND HYDRATION SHOULD NOT BE WITHDRAWN FROM PATIENTS. THEREFORE, THE COURT REFUSED THE HUSBAND'S REQUEST. THE CASE IS CURRENTLY ON APPEAL.

THE EXAMPLE OF THE CORBETT CASE GIVES CREDENCE TO WHAT PAUL RAMSEY, AN EMINENT AUTHORITY IN ETHICAL MATTERS, HAS SAID ABOUT LEGISLATION: "(IT) IS OUR LAST RESORT IF I AM CORRECT IN BELIEVING THAT THE COMMON LAW'S ANCIENT PROTECTION OF LIFE --- AGAINST ANY PRIVATE DECISION MAKERS AND AGAINST ANY CONSENSUS --- IS ERODING."

THE AMENDMENTS TO THE FLORIDA BILL CONCERNING NUTRITION AND HYDRATION OFFER ONE EXAMPLE OF LEGISLATIVE REFORM THAT MIGHT BE HELPFUL IN THIS AREA. THERE ARE SEVERAL OTHERS THAT MIGHT BE CONSIDERED.

FIRST IS THE PROTECTION OF VULNERABLE ADULTS. CARE OF THE AGED IS A PROFOUND SOCIAL PROBLEM THAT HAS MANY ASPECTS ASIDE FROM THOSE WHICH CONCERN US TODAY. MEDICALLY DEPENDENT, ELDERLY PERSONS ARE VULNERABLE IN A MEDICAL SENSE BECAUSE THEY ARE SEEN INFREQUENTLY BY PHYSICIANS, VULNERABLE IN A SOCIAL SENSE BECAUSE THEY ARE CUT OFF FROM A FAMILY ENVIRONMENT, AND VULNERABLE IN A POLITICAL SENSE BECAUSE THEY HAVE VERY LIMITED CAPACITY TO INFLUENCE THE MANY GOVERNMENTAL DECISIONS WHICH IN TURN INFLUENCE THEIR LIVES.

IT MAY BE IMPORTANT TO GIVE "VULNERABLE ADULTS" SPECIAL LEGISLATIVE PROTECTION. MINNESOTA HAS ADOPTED SUCH LEGISLATION. UNDER THIS LAW, PRIVATE PERSONS MAY INITIATE AN INVESTIGATION OF SUSPECTED ABUSE OF AN ADULT. THESE POWERS HAVE BEEN USED IN MEDICAL TREATMENT CASES. INVESTIGATIONS HAVE THE VIRTUE OF AVOIDING THE ADVERSARIAL PROCESS OF THE JUDICIARY; HOWEVER, THEY OFTEN OCCUR TOO LATE TO BENEFIT THE PARTICULAR PATIENT. THUS, THERE OUGHT TO REMAIN A ROLE FOR OTHER LAW ENFORCEMENT PERSONNEL, IF FOR NO OTHER REASON THAN TO DETER EGREGIOUS CASES OF ABUSE. MOREOVER, THIS ROLE NEEDS TO BE TAKEN SERIOUSLY.

A SECOND LEGISLATIVE APPROACH MIGHT BE THE ESTABLISHMENT OF MINIMAL CARE GUIDELINES FOR ELDERLY PATIENTS. THIS HAS BEEN ATTEMPTED, WITH GREAT CONTROVERSY AND SOME SUCCESS, IN THE CARE OF HANDICAPPED INFANTS. THE "BABY DOE" LEGISLATION PASSED IN 1984, AND THE AMENDMENTS TO CHILD ABUSE ACCOMPANYING REGULATIONS ISSUED IN 1985, REQUIRE THAT BENEFICIAL MEDICAL TREATMENT BE PROVIDED TO EVERY INFANT. TREATMENT NEED NOT BE PROVIDED IN THREE SITAUTIONS:

* WHERE THE INFANT IS IRREVERSIBLY COMATOSE.
* WHERE THE TREATMENT WOULD MERELY PROLONG DYING AND BE FUTILE IN TERMS OF THERAPEUTIC VALUE.
* WHERE THE TREATMENT WOULD BE FUTILE, AND INHUMANE UNDER THE CIRCUMSTANCES.

THESE EXCEPTIONS, HOWEVER, DO NOT PERMIT THE WITHHOLDING OF NUTRITION AND HYDRATION.

GIVEN THE CURRENT CONTROVERSY OVER THESE ISSUES, THE ESTABLISHMENT OF SIMILAR GUIDELINES FOR THE ELDERLY MAY BE DIFFICULT TO ACHIEVE. IN ADDITION, DECISIONS AT THE END OF LIFE ARE IN SOME WAYS MORE DIFFICULT THAN THOSE AT THE BEGINNING. WITH AN INFANT, THERE IS THE HOPE AND POTENTIAL OF A LIFETIME STILL TO BE LIVED.

THIS IS NOT THE CASE WITH THE ELDERLY. IN ADDITION, IN SOME NARROWLY DEFINED CIRCUMSTANCES, NUTRITION AND HYDRATION OF AN ELDERLY PATIENT MAY NOT BE THE MOST APPROPRIATE COURSE OF TREATMENT FROM A PURELY MEDICAL POINT OF VIEW. NEVERTHELESS, THERE IS A NEED FOR LINE-DRAWING IN THIS AREA.

ON THE QUESTION OF NUTRITION, THE LINE MIGHT BE DRAWN AS FOLLOWS: NUTRITION THROUGH THE GASTRO-INTESTINAL TRACT MUST BE PROVIDED TO PATIENTS UNLESS THERE ARE CLEAR MEDICAL CRITERIA TO THE CONTRARY. EXAMPLES OF SUCH CRITERIA INCLUDE FUTILITY -- WHERE THE PATIENT IS IN THE LAST HOURS OF LIFE, OR WHERE THE PATIENT CANNOT METABOLIZE OR OTHERWISE BENEFIT FROM NUTRITION. MOREOVER, THE CHOICE OF MODALITIES FOR PROVIDING NUTRITION AND HYDRATION WILL BE AFFECTED IN INDIVIDUAL CASES BY THE CERTAINTY OF OUTCOME, THE GEOGRAPHICAL LOCATION OF THE PATIENT, THE PROGNOSIS FOR TIME REMAINING IN LIFE, AND THE BENEFIT TO BE DERIVED FROM ONE ROUTE OF NUTRITION OVER ANOTHER. THE AIM OF SUCH LEGISLATION MUST BE TO PREVENT CASES OF ABUSE AND ABANDONMENT, AND NOT TO MAKE DIFFICULT MEDICAL DECISIONS MORE DIFFICULT.

A FINAL OPTION FOR DEATH AND DYING LEGISLATION IS TO PROTECT THE RIGHT TO CONSENT TO TREATMENT MORE THAN IT IS CURRENTLY PROTECTED UNDER LIVING WILL LAWS. THE PROPOSED FORMS OF LIVING WILLS THAT ARE CONTAINED IN LEGISLATION MIGHT BE EXPANDED TO PROVIDE A WIDER RANGE OF PATIENT CHOICE. AT THE VERY LEAST, PATIENTS OUGHT TO BE GIVEN THE RIGHT TO REQUEST AS WELL AS TO REFUSE MEDICAL TREATMENT. NEITHER RIGHT SHOULD BE ABSOLUTE, HOWEVER.

ANOTHER OPTION IS THAT GIVEN BY A HANDFUL OF STATES: TO MAKE THE LIVING WILL ADVISORY, BUT NOT BINDING, UPON PHYSICIANS AND INSTITUTIONS. THERE IS NO EMPIRICAL EVIDENCE TO ESTABLISH THAT PATIENT DIRECTIVES WILL BE IGNORED BY PHYSICIANS UNLESS THEY ARE MADE LEGALLY BINDING. INDEED, SUCH DIRECTIVES MIGHT BE MORE READILY ACCEPTED BY THE MEDICAL COMMUNITY IF THEY ARE ADVISORY IN NATURE. WITHOUT MAKING THE DIRECTIVE BINDING, A STATUTE MAY STILL GIVE IMMUNITY TO PHYSICIANS FOR GOOD-FAITH DECISIONS THAT ARE MADE IN RELIANCE UPON A LIVING WILL. THIS WOULD ACCOMPLISH A GREAT DEAL IN CLARIFYING THE LEGAL RIGHTS AND RESPONSIBILITIES FOR SUCH DECISIONS.

EVEN IF THESE SUGGESTIONS ARE ADOPTED AND AN IMPROVED FORM OF LIVING WILL LEGISLATION IS ENACTED, THE COURTS WILL REMAIN CRUCIAL TO LEGAL DEVELOPMENTS PERTAINING TO EUTHANASIA. THIS HAS BEEN EVIDENT EVER SINCE THE LANDMARK OPINION OF THE NEW JERSEY SUPREME COURT IN THE KAREN QUINLAN CASE. THE CIRCUMSTANCES OF THAT CASE REMIND US OF LIMITATIONS THAT WE FACE IN ADDRESSING THESE ISSUES. KAREN QUINLAN WAS REFERRED TO BY THE COURT AS A MORIBUND, ON THE BASIS OF ALL EXPERT TESTIMONY DYING PATIENT. IT WAS FURTHER PRESUMED THAT SHE COULD NOT BE SUCCESSFULLY WEANED FROM HER RESPIRATOR. THE DECISION WAS RENDERED ON THESE PREMISES, BOTH OF WHICH TURNED OUT TO QUITE INACCURATE.

THE DECISION OF THE NEW JERSEY COURT, NONETHELESS, HAS BEEN WIDELY FOLLOWED IN SEVERAL STATES. ONE ONLY STATE HIGH COURT--NEW YORK--HAS EXPLICITLY REFUSED TO APPLY THE FUNDAMENTAL DOCTRINES OF QUINLAN TO SIMILAR FACTUAL CIRCUMSTANCES.

THE QUINLAN DOCTRINE MIGHT BE SUMMARIZED AS FOLLOWS: AN INCOMPETENT PATIENT HAS A CONSTITUTIONAL RIGHT OF PERSONAL AUTONOMY WHICH INCLUDES A RIGHT TO REFUSE MEDICAL TREATMENT, EVEN THAT WHICH IS LIFE-SAVING.

THAT RIGHT CAN BE EXERCISED ON BEHALF OF THE INCOMPETENT PATIENT BY A FAMILY MEMBER OR GUARDIAN. FINALLY, THE STATE INTEREST IN PRESERVING LIFE CANNOT INTERFERE WITH THE EXERCISE OF THE PATIENT'S PRIVACY RIGHTS WHERE THE PATIENT'S PROGNOSIS IS DIM.

SHORTLY AFTER THE QUINLAN CASE WAS DECIDED, PROFESSOR KAMISAR PREDICTED THAT THESE HOLDINGS WOULD ERODE LEGAL SANCTIONS AGAINST EUTHANASIA BY FORGING A LINK BETWEEN VOLUNTARY EUTHANASIA -- THE PRACTICE OF EUTHNASIA ON REQUEST -- WITH INVOLUNTARY EUTHANASIA. IN ESSENCE, THE QUINLAN COURT CREATED A RIGHT TO DIE AND GAVE IT CONSTITUTIONAL PROTECTION. FURTHERMORE, IT STATED THAT THIS RIGHT TO DIE CAN BE EXERCISED ON BEHALF OF INCOMPETENT PATIENTS BY THIRD PARTIES---EVEN WHEN IT IS NOT CLEAR THAT THE PATIENT WOULD CHOOSE TO EXERCISE THE RIGHT. IF EUTHANASIA ON REQUEST WERE EVER TO BE GRANTED CONSTITUTIONAL PROTECTION, OR TO BE PERMITTED BY LEGISLATION, THE QUINLAN DOCTRINE WOULD GIVE A LEGAL BASIS FOR EXTENDING THE PRACTICE TO NON-COMPETENT PATIENTS.

THAT THIS HAS NOT HAPPENED IS ATTRIBUTABLE TO SEVERAL FACTORS, INCLUDING THE SAFEGUARDS BUILT INTO CERTAIN JUDICIAL OPINIONS. PERHAPS THE MOST COMPREHENSIVE SET OF SAFEGUARDS WAS RECENTLY ADOPTED BY THE SAME NEW JERSEY SUPREME COURT IN THE CASE OF CLAIRE CONROY.

CONROY PRESENTED THE COURT WITH THE QUESTION OF WHETHER A NASO GASTRIC FEEDING TUBE CAN BE REMOVED FROM A SEMI-CONSCIOUS, BEDRIDDEN, NURSING HOME PATIENT WHERE DEATH IS EXPECTED IN A YEAR OR LESS. CLAIRE CONROY HERSELF DIED LONG BEFORE HER CASE REACHED THE HIGH COURT, BUT JURISDICTION WAS MAINTAINED BECAUSE OF THE IMPORTANT PUBLIC POLICY RAMIFICATIONS OF THE CASE. WITH NO LIVE PATIENT IN FRONT OF IT, AND WITH NO GUIDANCE FROM THE LEGISLATURE, THE COURT TREATED THE CONROY CASE AS AN OPPORTUNITY TO CREATE RULES OF ITS OWN IN THIS AREA.

THE FIRST QUESTION FACING THE COURT WAS HOW TO TREAT THE PRECEDENT OF QUINLAN. THE COURT AGREED THAT THE PATIENT'S RIGHT TO SELF-DETERMINATION WAS THE FUNDAMENTAL LEGAL DOCTRINE AT ISSUE. HOWEVER, IT DID NOT RE-AFFIRM QUINLAN's HOLDING THAT THIS RIGHT IS CONSTITUTIONALLY PROTECTED.

INSTEAD, THE COURT HELD THAT THIS RIGHT IS ADEQUATELY PROTECTED BY THE COMMON LAW. IN ADDITION, IT INVITED THE LEGISLATURE TO MODIFY ITS RULING ON THE CIRCUMSTANCES IN WHICH THAT RIGHT CAN BE EXERCISED FOR NURSING HOME PATIENTS.

THE COURT DEPARTED MORE SHARPLY FROM QUINLAN ON THE ISSUE OF SUBSTITUTED JUDGMENT. UNDER QUINLAN, THE CONSTITUTIONAL RIGHT TO REFUSE TREATMENT APPLIED REGARDLESS OF WHETHER THE PATIENT'S SPECIFIC WISHES REGARDING TREATMENT WERE KNOWN. THE CONROY COURT, HOWEVER, REJECTED THIS APPROACH. "A SURROGATE DECISION-MAKER CANNOT PRESUME," THE COURT SAID, "THAT TREATMENT DECISIONS MADE BY A THIRD PARTY ON THE PATIENT'S BEHALF WILL FURTHER THE PATIENT'S RIGHT TO SELF-DETERMINATION, SINCE EFFECTUATING ANOTHER PERSON'S RIGHT TO SELF-DETERMINATION PRESUPPOSES THAT THE SUBSTITUTE DECISION-MAKER KNOWS WHAT THE PERSON WOULD HAVE WANTED. THUS, IN THE ABSENCE OF ADEQUATE PROOF OF THE PATIENT'S WISHES, IT IS NAIVE TO PRETEND THAT THE RIGHT TO SELF-DETERMINATION SERVES AS THE BASIS FOR SUBSTITUTE DECISION-MAKING."

AS AN ALTERNATIVE TO SUBSTITUTED JUDGMENT, THE COURT ESTABLISHED THREE TESTS UNDER WHICH DECISIONS CAN BE MADE TO WITHDRAW LIFE-SUSTAINING TREATMENT FROM PATIENTS IN MISS CONROY'S CIRCUMSTANCES: A SUBJECTIVE TEST, A LIMITED OBJECTIVE TEST, AND A PURE OBJECTIVE TEST.

UNDER THE SUBJECTIVE TEST, THE WISHES OF THE PATIENT ARE CONTROLLING. IF AN INCOMPETENT PATIENT HAS LEFT CLEAR EVIDENCE REGARDING HIS PREFERENCES FOR MEDICAL TREATMENT, THOSE PREFERENCES SHOULD BE HONORED. THE PATIENT CAN CHOOSE TO REQUEST OR FOREGO TREATMENT. FURTHERMORE, THE DIRECTIVE SHOULD BE SPECIFIC--THE COURT INDICATED THAT A GENERAL STATEMENT, SUCH AS THAT CONTAINED IN MANY LIVING WILLS, IS NOT SPECIFIC ENOUGH, STANDING ALONE, TO MEET THE SUBJECTIVE TEST.

UNDER THE LIMITED OBJECTIVE TEST, TREATMENTS CAN BE WITHDRAWN IF THE INCOMPETENT PATIENT HAS LEFT BEHIND SOME TRUSTWORTHY EVIDENCE THAT HE WOULD HAVE REFUSED THE TREATMENT. FURTHERMORE, THE BURDENS OF LIFE WITH THE TREATMENT MUST OUTWEIGH THE BENEFITS OF THAT LIFE. THE COURT RULED THAT BURDENS MUST BE UNDERSTOOD IN A VERY NARROW SENSE. THE ONLY TYPE OF BURDEN THAT WILL JUSTIFY

THE WITHDRAWAL OF TREATMENT IS UNREMITTING, UNALLEVIATED PAIN AND SUFFERING THAT IS EXPECTED TO LAST FOR THE REMAINDER OF THE PATIENT'S LIFE.

FINALLY, UNDER THE PURE OBJECTIVE TEST, A DECISION TO WITHDRAW TREATMENT CAN BE MADE WHEN AN INCOMPETENT PATIENT IS SUFFERING SUCH UNREMITTING PAIN, EVEN IF THE PATIENT HAS LEFT NO TRUSTWORTHY EVIDENCE OF WHAT HE WOULD DECIDE TO DO IN THE SITUATION.

THE CONROY OPINION CREATES A STRONG INCENTIVE FOR ATIENTS TO WRITE CLEAR AND SPECIFIC DIRECTIONS REGARDING THEIR FUTURE MEDICAL TREATMENT. THE OPINION ALSO LIMITS THE TYPE OF TREATMENT DECISIONS THAT CAN BE MADE WHEN SUCH DIRECTIONS HAVE NOT BEEN PROVIDED. BUT THESE ARE NOT THE ONLY SAFEGUARDS THAT THE COURT PROVIDES. THERE ARE THREE ADDITIONAL, PROCEDURAL SAFEGUARDS.

FIRST, THERE MUST BE CLEAR AND CONVINCING EVIDENCE, THE HIGHEST STANDARD UNDER THE CIVIL LAW, THAT THE PATIENT DOES NOT HAVE AND NEVER WILL REGAIN THE CAPACITY TO MAKE DECISIONS FOR HIMSELF. THIS EVIDENCE MUST BE PROVIDED BY WO QUALIFIED PHYSICIANS WHO HAVE EXAMINED THE PATIENT.

SECOND, THE STATE OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY MUST BE NOTIFIED WHENEVER A DECISION TO REMOVE TREATMENT UNDER ANY OF THE THREE TESTS IS CONTEMPLATED. THE OMBUDSMAN MUST INVESTIGATE EVERY REPORTED CASE AS A CASE OF POTENTIAL ABUSE OF THE ELDERLY. HE MUST ARRANGE FOR AN INDEPENDENT MEDICAL EXAMINATION BY TWO PHYSICIANS FROM OUTSIDE THE NURSING HOME.

THIRD, IF ALL OF THE PHYSICIANS CORROBORATE THE MEDICAL DIAGNOSIS, AND THE OMBUDSMAN AGREES THAT ONE OF THE THREE TESTS IS SATISFIED, THE PATIENT'S GUARDIAN MAY THEN DIRECT THAT TREATMENT BE WITHDRAWN.

ONE MAY QUESTION WHY SAFEGUARDS OF SUCH MAGNITUDE ARE REQUIRED. THE ANSWER LIES IN A CLOSE EXAMINATION OF THE SUBJECTIVE TEST. UNDER THAT TEST, THE COURT HAS LEFT ROOM FOR THE PRACTICE OF PASSIVE EUTHANASIA BY REQUEST. THE COURT HELD THAT ANY TREATMENT--INCLUDING NUTRITION AND HYDRATION BY ANY MECHANICAL MEANS--CAN BE WITHHELD, PROVIDED THE DIRECTIONS ARE SPECIFIC, AND THE PATIENT IS EXPECTED TO DIE WITHIN THE YEAR. THERE IS NO COUNTERVAILING STATE INTEREST IN SUCH CASES TO PRESERVE LIFE.

HAVING CREATED A MECHANISM THAT MIGHT PERMIT THE PRACTICE OF PASSIVE EUTHANASIA IN A SMALL NUMBER OF CASES, THE COURT WENT TO GREAT LENGTHS TO PREVENT EUTHANASIA FROM BEING PRACTICED ON A LARGER POPULATION OF INCOMPETENT PATIENTS. THE PROTECTIONS ARE SO EXTENSIVE THAT THEY MAY INTERFERE WITH PERFECTLY VALID DECISIONS TO FOLLOW NON-AGGRESSIVE TREATMENT PLANS FOR THE TERMINALLY ILL. THIRTY YEARS AGO, PROFESSOR KAMISAR NOTED THAT IT IS PRACTICALLY IMPOSSIBLE TO WRITE EUTHANASIA LEGISLATION THAT WILL BOTH PROTECT THE RIGHT TO EUTHANASIA FOR THOSE OF SOUND MIND WHO REQUEST IT, AND ALSO PREVENT ABUSIVE PRACTICES. HIS THESIS IS GIVEN CREDENCE BY THE CONROY OPINION.

ON BALANCE, HOWEVER, IT IS POSSIBLE THAT THE CONROY OPINION MAY STRENGTHEN EXISTING LAWS AGAINST EUTHANASIA. BY REJECTING THE DOCTRINE OF SUBSITUTED JUDGMENT AS A VALID BASIS FOR TREATMENT DECISIONS, THE COURT HAS DAMAGED ONE OF THE CRITICAL, AND MOST THREATENING, HOLDINGS OF QUINLAN. THE EVENTUAL IMPACT OF CONROY WILL DEPEND LARGELY UPON WHETHER ITS CRITICISMS OF SUBSTITUTED JUDGMENT ARE HONORED IN FUTURE OPINIONS.

IN ADDITION, THE PARTICIPATION OF THE STATE OMBUDSMAN PRIOR TO ANY DECISION THAT MIGHT RESULT IN EUTHANASIA COULD HAVE A STRONG DETERRENT EFFECT. AGAIN, IT REMAINS TO BE SEEN HOW THIS HOLDING OF CONROY WILL BE IMPLEMENTED. IF THE OMBUDSMAN ACTS AS AN ADVOCATE FOR THE LIFE OF THE PATIENT, THE PRACTICE OF EUTHANASIA BY OMISSION, AT LEAST FOR THOSE PATIENTS WHO HAVE NOT REQUESTED IT, WILL BE PREVENTED. HOWEVER, IF THE OMBUDSMAN IS INFLUENCED BY FACTORS SUCH AS THE COST OF TREATMENT AND THE PATIENT'S "QUALITY OF LIFE," THE INTENTIONS OF THE CONROY COURT WILL BE FRUSTRATED, AND THE PRACTICE OF EUTHANASIA MAY RECEIVE THE TACIT APPROVAL OF THE STATE.

THE NEW JERSEY COURT MAY SOON GET A CHANCE TO RE-EXAMINE THE CONROY OPINION. PAUL ARMSTRONG, THE MORRISTOWN ATTORNEY WHO REPRESENTED THE PARENTS OF KAREN QUINLAN, IS NOW REPRESENTING A FAMILY THAT WISHES TO HAVE A FEEDING TUBE REMOVED FROM A PATIENT VERY SIMILAR TO KAREN QUINLAN. THE PATIENT, NANCY JOBES, IS 30 YEARS OLD, AND IS IN A PERSISTENT VEGETATIVE STATE. SHE IS NOT ELDERLY, SHE IS NOT TERMINALLY ILL, AND SHE HAS APPARENTLY LEFT NO CLEAR DIRECTIVE REGARDING MEDICAL TREATMENT.

THE MASSACHUSETTS SUPREME COURT WILL ~~ALSO~~ FACE A SIMILAR QUESTION IN THE CASE OF PAUL BROPHY, A 45 YEAR-OLD PATIENT, ALSO IN A PERSISTENT VEGETATIVE STATE. A TRIAL COURT IN NORFOLK COUNTY HAS REJECTED THE REQUEST OF THE BROPHY FAMILY TO REMOVE HIS GASTROSTOMY FEEDING TUBE. THE COURT HELD THAT THE RESULTING DEATH BY STARVATION AND DEHYDRATION WOULD BE AN INHUMANE ACT OF EUTHANASIA. EVEN IF THE PATIENT WOULD WANT THE TUBE WITHDRAWN, THE COURT HELD, THIS TYPE OF TREATMENT OMISSION SHOULD NOT BE PERMITTED.

THIS CONCLUDES MY REVIEW OF CURRENT LEGAL DEVELOPMENTS. IF NOTHING ELSE, I HOPE I HAVE LEFT YOU WITH THE KNOWLEDGE THAT THERE ARE MANY TYPES OF LEGAL DEVELOPMENTS THAT MAY AFFECT THE PRACTICE OF EUTHANASIA, AND THAT THE EFFORT TO COMBAT EUTHANASIA MUST BE FOUGHT ON MANY FRONTS.

THE TESITMONY OF DR. LEO ALEXANDER IS JUST AS TRENCHANT NOW AS IT WAS IN THE 1940s. NO SOCIETY CAN RISK THE PROFOUND EVIL OF DE-VALUING THE LIFE OF ANY HUMAN BEING, NO MATTER HOW PROFOUNDLY THAT LIFE MAY BE IMPAIRED.

OUR EFFORT TO CARRY ON THE LEGACY OF MEN SUCH AS DR. ALEXANDER WILL BE DIFFICULT. THIS SHOULD NOT SURPRISE US, FOR THE ISSUE OF EUTHANASIA IS COMPLEX ISSUE OF HUMAN RIGHTS AND RESPONSIBILITIES. EASY SOLUTIONS, AND ALL OR NOTHING POLITICAL POSITIONS WILL NOT BE ADEQUATE OR EFFECTIVE IN MEETING THE CHALLENGE OF THIS ISSUE. IT IS ALSO OUT OF THE QUESTION FOR US TO SAY, WITH COMPLACENCY, THAT "IT CAN'T HAPPEN HERE." SINCE THIS IS AN AUDIENCE OF LAWYERS AND LAW STUDENTS, I WILL LEAVE YOU WITH PROFESSOR YALE KAMISAR'S RETORT TO THAT ARGUMENT.

"IT CAN'T HAPPEN HERE. WELL, MAYBE IT CANNOT, BUT NO SMALL PART OF OUR CONSTITUTION AND NO SMALL NUMBER OF OUR SUPREME COURT OPINIONS STEM FROM THE FEAR THAT <u>IT CAN HAPPEN HERE UNLESS WE DARN WELL MAKE SURE THAT IT DOES NOT</u> BY ADAMANTLY HOLDING THE LINE, BY SWIFTLY SNUFFING OUT WHAT ARE OR MIGHT BE THE SMALL BEGINNINGS OF WHAT WE DO NOT WANT TO HAPPEN HERE.

"TO FLICK OFF THE FEARS ABOUT LEGALIZED EUTHANASIA AS SO MUCH NONSENSE, AS A "PARADE OF HORRORS", IS TO SWEEP AWAY MUCH OF THE GROUND ON WHICH ALL OUR CIVIL LIBERTIES REST."

I THANK YOU FOR THE OPPORTUNITY TO ADDRESS YOU THIS AFTERNOON, AND I LOOK FORWARD TO RESPONDING TO ANY QUESTIONS YOU MIGHT HAVE.

JOINING ME WILL BE MR ED GRANT - EXEC AUL DEFENSE FUND. AS YOU MIGHT SURMISE THE MSS SUBMITTED TO YOUR JOURNAL ON THIS OCCASION DIFFERS SOMEWHAT FROM MY SPOKEN REMARKS. MR GRANT IS CO-AUTHOR OF THAT PAPER.